

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155574</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLER'S MERRY MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>500 WALKERTON TR WALKERTON, IN 46574</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Preoccupancy Survey for the expanded therapy area was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 09/09/15</p> <p>Facility Number: 000431 Provider Number: 155574 AIM Number: 100290380</p> <p>At this Life Safety Code Preoccupancy survey, the Miller's Merry Manor therapy expansion addition was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The Therapy addition was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with automatic smoke detection in the corridors and in areas open to the corridors. All 63 resident rooms were provided with battery operated smoke detectors. The facility has a capacity of 107 and had a census of 68 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review completed on 09/14/15 - DA</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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